COBRA Process for Involuntarily Terminating More Than One Employee

Process for ARRA Affected Ex-employees when more than one employee is involved

1. When an employer plans to terminate two or more employees involuntarily, the employer should contact the EUTF immediately. Examples of involuntary termination include:

    a. Temporary employees with a termination date such as those working at the legislature
    b. Employees that terminate due to end of a contract
    c. Employees placed on furlough
    d. Employees terminated due to the termination of a position
    e. For more details, refer to IRS Notice 2009-27 (excerpt attached)

2. When EUTF receives notice of a mass layoff, EUTF will provide the following to the employer to provide each potentially terminating employee:

    a. Request for Treatment as an Assistance Eligible Individual
    b. COBRA Continuation of Coverage Election Notice

3. When the employer finalizes the termination date, the employer should immediately report the termination by completing an EC-1 form for each person and entering in the EVENT field, Involuntary Termination.

    a. Submit the completed EC-1 form in according with current COBRA instructions, within 30 days of the termination date.

    b. Complete and submit the employer portion of the Treatment as an Assistance Eligible Individual form with the EC-1 if the employee is involuntarily terminated. This form certifies that the employee was involuntarily terminated and is eligible for the premium subsidy.

4. The EUTF will process the EC-1 form and generate and send the COBRA Election Notice and Election Form to the qualified beneficiaries.

5. The qualified beneficiaries have up to 60 days from the Notification Date to decide whether or not they want to elect COBRA continuation coverage under the Plan.

6. Once the EUTF receives the election forms from the qualified beneficiaries, the EUTF will forward copies to the affected insurance carriers.

7. The Carrier forwards COBRA application/payment information to the qualified beneficiary.

8. The qualified beneficiary sends 35% of the premium payment to the Carrier. . If payment is sent late or not received, after the grace period, the individual should be terminated. If the payment is "short," it must be significantly short to automatically terminate. Carriers should send a follow-up request with a short suspense, no more than one week, before terminating The carrier should not include these people on the detailed list until they pay the full 35%. If they do not pay the full 35%, then they should terminate their coverage.

9. If the qualified beneficiary's coverage is retroactive and the qualified beneficiary has already made 100% of COBRA premium payment to the carrier, then the carrier will apply the qualified beneficiary's over payment toward future premium payments or refund as appropriate.

10. Carrier notifies the EUTF on a monthly basis that it has received the 35% payment from the qualified beneficiary. The carrier will provide a detailed list to the EUTF for 65% of the premium. The list must include the qualified beneficiary's name, dependent's name (if any), social security number, total premium amount (65%) and type of coverage for each qualified beneficiary. The 35% premium that the qualified beneficiary paid is applied to the total claim charges (i.e., not the claim charges for the qualified beneficiary) in determining how much additional payment is due from the EUTF to the carrier for the particular month.

11. The EUTF sends an invoice with the supporting documents to the Employer for 65% of the premium and the employer will pay the EUTF. The EUTF will prepare specific instructions for the employer regarding the subsidy process and provide these instructions to the employers in the near future.

12. The Employer uses the invoice as part of the proof to claim the temporary COBRA premium subsidy from the federal government.

13. The Carrier will monitor when the maximum 9 months of subsidy is met.

Attachments

a. Request for Treatment as an Assistance Eligible Individual
b. COBRA Election Notice
c. IRS Definition of Involuntary Termination

Hawaii Employer-Union Health Benefits Trust Fund	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	P.O. Box 2121 Honolulu Hawaii 96805

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the next page)	Telephone Number E-mail address (optional)

TO QUALIFY, YOU MUST BE ABLE TO CHECK "YES" FOR ALL STATEMENTS.*

1. The loss of employment was involuntary	☐ Yes	☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	☐ Yes	☐ No
3. I elected (or am electing) COBRA continuation coverage.*	☐ Yes	☐ No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium.)	☐ Yes	☐ No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium.)	☐ Yes	☐ No

***If you checked NO for Statement 3, you may still be eligible. See below for more information**

If your COBRA continuation coverage relates to an involuntary loss of employment prior to or on December 31, 2009, and you were eligible for, but waived COBRA coverage, you still have the right to to revoke your waiver and elect to enroll in COBRA. You must, however, revoke and submit your waiver in writing within the 60-day election period. In this scenario, your COBRA start date may begin on the date your waiver is revoked and therefore, your premium subsidy will not begin until that date. You can contact the EUTF at 586-7390 or toll free at 808-295-0089 or at 201 Merchant Street, Suite 1520, Honolulu Hawaii 96813 or go to our website at www.eutf.hawaii.gov for more information.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature _____ Date_____

Type or print name:_____ Relationship to Employee:

FOR EMPLOYER VALIDATION

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #4 below)

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary	☐
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	☐
3. Individual was not enrolled in a health benefit plan when terminated.	☐

4. Other (please explain)

Signature of employer:

Signature _____ Date_____

Type or print name:_____	Position Title_____
Telephone Number:_____	E-mail address:_____

To apply for ARRA Premium Reduction, complete this form and return it to the EUTF along with you COBRA Election Form.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual to the EUTF at P.O. Box 2121, Honolulu HI 96805 or you can deliver it to our office at 201 Merchant Street, Suite 1520, Honolulu Hawaii 96813.

Be sure to read the important information about your rights and responsibilities included in the "Summary of the COBRA Premium Reduction Provisions under ARRA." For more detailed information, please access our website at www.eutf.hawaii.gov.

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL (continued)

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name	Date of Birth	Relationship	SSN
a.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
b.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
c.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
d.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
e.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

NOTE: If there are more dependents, please make a copy of this page and complete it for your additional dependents.

Hawaii Employer-Union
Health Benefits Trust Fund

IMPORTANT DOCUMENT

This COBRA ELECTION NOTICE contains important information and instructions regarding your health benefits continuation coverage under COBRA.

You have recently experienced a COBRA qualifying event and may qualify for COBRA continuation of coverage for health benefits.

The American Recovery and Reinvestment Act of 2009 provides additional benefits for certain qualified beneficiaries by providing COBRA premium assistance.

If you fail to comply with these instructions, you may lose your eligibility for COBRA continuation of coverage.

YOUR RESPONSE IS TIME SENSITIVE. PLEASE READ THESE INSTRUCTIONS CAREFULLY

IMPORTANT DOCUMENT

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

COBRA Continuation Coverage Election Notice

This notice contains important information about additional rights to continue your health care coverage in the Hawaii Employer-Union Health Benefits Trust Fund's (EUTF) group health plan(s) (the Plan).

Please read the information contained in this notice very carefully. The pronouns "you" and "your" refer to each of the individuals identified on the Continuation Coverage (COBRA) Election Form included with this notice. This notice provides important information concerning your rights under a federal law known as COBRA, and what you have to do to continue your health care coverage under the Plan. If you have any questions concerning the information in this notice or your rights to coverage under COBRA, you should contact:

Hawaii Employer-Union Health Benefits Trust Fund
Attn: COBRA Coordinator
P.O. Box 2121
Honolulu, HI 96805-2121
Telephone: (808) 586-7390
Toll Free: (800) 295-0089

FOR THOSE WHO WERE INVOLUNTARILY TERMINATED: The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. ARRA allows those individuals who were **involuntarily terminated** and loss health benefits coverage between March 1, 2009 and December 31, 2009 to enroll in COBRA at a reduced premium. If your loss of health coverage was due to an **involuntary termination of employment,** you may be eligible for temporary premium reduction for up to nine months. To help determine whether you are eligible to receive the ARRA premium reduction, you should read this notice and the attached documents carefully. In particular, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations **If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual" and return it with your completed COBRA Election Form.**

To elect COBRA continuation coverage, you must follow the instructions on the "COBRA Continuation Coverage Election Form" provided and return the completed, signed and dated enclosed COBRA Election Form to us by mail within the time period described below.

By mail: Hawaii Employer-Union Health Benefits Trust Fund
Attn: COBRA Coordinator
P.O. Box 2121
Honolulu, HI 96805-2121

By hand-delivery: Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1520
Honolulu, HI 96805

Each person ("Qualified Beneficiary") listed for each COBRA option on the COBRA Election Form is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan until the date noted on the cover letter. The qualified beneficiaries listed on the form are the only persons eligible to enroll in COBRA.

If elected, COBRA continuation coverage will begin retroactively on March 1, 2009 or the date of your qualifying event, whichever is later, and will last until up to 18 months after the Qualifying Event Date shown on your COBRA Election Form. If you qualify, your COBRA subsidy will be for nine months beginning with the effective date of your COBRA coverage. If your COBRA coverage period goes beyond the nine months, your premiums will revert to the standard rate of 102% of the actual premiums.

The cost of COBRA continuation coverage will be based on your plan selections and the type of coverage you desire. You are eligible to enroll only in the plans listed on your COBRA Election Form. If you qualify as an "Assistance Eligible Individual" this cost can be reduced to 35% of the cost of the plans that you select for up to nine months. You do not have to send any payment with the COBRA Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the instructions for the COBRA Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact the EUTF:

Attn: COBRA Coordinator
P.O. Box 2121
Honolulu, HI 96805-2121
Telephone: (808) 586-7390
Toll Free: (800) 295-0089

CONTINUATION COVERAGE (COBRA) ELECTION FORM

Fname MI Lname		**EmplID:**	**HBXXXXXXX**
Address		**Notification Date:**	**MM/DD/YYYY**
CitySt Zipcode			
First day of COBRA coverage:	MM/DD/YYYY	Qualifying Event:	Job Termination
Period of COBRA coverage:	18 months	Qualifying Event Date:	MM/DD/YYYY

PART A: COBRA Participation

☐ **I am electing COBRA continuation coverage (Complete Part B and sign Part C).**

☐ **I am waiving COBRA continuation coverage (Skip Part B and sign Part C).**

If you want your COBRA information sent to an alternate address, enter your complete alternate address here: _____

PART B: COBRA Plan Elections and Payment Options

I wish to continue coverage(s) indicated below:

YOUR COBRA OPTIONS	**Self Only**	**Two-Party**	**Family**	**Dependents**
Medical				
Medical plan	☐	☐	☐	**Name1** **Name2**
Dental				
Dental plan	☐	☐	☐	**Name1** **Name2**
Vision				
Vision plan	☐	☐	☐	**Name1** **Name2**
Prescription Drugs				
Drug plan	☐	☐	☐	**Name1** **Name2**
Chiropractic				
Chiro plan	☐	☐	☐	**Name1** **Name2**

PART C: Participant Signature

I understand that I must submit my COBRA election to the EUTF no later than the reply deadline. I understand that to qualify for the premium subsidy due to an **INVOLUNTARY TERMINATION OF EMPLOYMENT**, I must submit a completed REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL form to the EUTF. I also understand that my eligibility for the premium subsidy must be validated by my previous employer before I can be enrolled.

SIGNATURE:_____ DATE:_____

NOTE: A parent must sign for a minor if needed

Continuation Coverage (COBRA) Election Form Instructions

INSTRUCTIONS: To elect COBRA continuation coverage, you MUST complete the enclosed COBRA Election Form and return the signed and dated form to us. Under federal law, you must have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan. You may mail, fax or hand-deliver the completed COBRA Election Form.

By mail: Hawaii Employer-Union Health Benefits Trust Fund
Attn: COBRA Coordinator
P.O. Box 2121
Honolulu, HI 96805-2121

By hand-delivery: Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1520
Honolulu, HI 96805

By fax: (808) 586-2161

You must complete this COBRA Election Form and return it to us within 60 calendar days after the Notification date, If sent by mail, it must be post-marked no later than 60 calendar days after the Notification Date on the letter. If you fax or deliver the completed form, it must arrive at the EUTF no later than 60 calendar days after the Notification Date on the letter.

The following are not acceptable as COBRA elections and will not preserve your COBRA continuation coverage rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's desire to elect COBRA; and electronic or e-mail communications.

IF YOU DO NOT SUBMIT A COMPLETED COBRA ELECTION FORM BY THE DUE DATE (by the 60th calendar day), YOU WILL LOSE YOUR RIGHT TO ELECT COBRA CONTINUATION COVERAGE. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit a completed COBRA Election Form by the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin not on the first day you lost coverage, but (after we receive your first COBRA premium payment) on the date you furnish the completed COBRA Election Form.

Specific Instructions about your election notice form

1. **Notification Date: The notification date is the reference date to which you need to be aware. Your COBRA election form is due to EUTF no later than 60 calendar days after this date.**
2. **First Day of Coverage: Your first day of coverage is the day after you were terminated from the EUTF group health plan. This day is determined by the COBRA law and cannot be changed except as noted above.**
3. **Your last day of coverage can be moved up if specific events occur. Please read the enclosed election notice document for specific information.**
4. **On the COBRA Election Form itself:**

<u>Header</u>

   a. **Qualifying Event: This is the COBRA qualifying event that, by Federal law, requires your employer to provide continued health benefits coverage at your expense.**
   b. **Date of Qualifying Event: Your continuation of coverage begins beyond this date. If your dependents were covered under the Plan on the last day of active coverage, their benefits can also continue.**

<u>Part A: COBRA participation</u>

   a. **If you decide to waive your right to COBRA, check the appropriate box, sign the form and submit it to the Plan.**
   b. **If any of your qualified dependents chooses to enroll individually, complete the individual election forms provided for each family member choosing to enroll separately. You may still enroll the rest of the family under your or your spouse's enrollment (as applicable).**
   c. **If a family member lives separately (in school) and chooses to enroll separately, please provide an address to ensure that the proper documents are sent to the correct member.**

<u>Part B:</u> The plans and qualified beneficiaries listed are those that were active on the last day of coverage. You may only enroll in those plans that you had been enrolled on the last day of coverage.

<u>Part C:</u> Please complete this form by signing the form. Failure to submit a complete, signed form may cause you to become ineligible for COBRA benefits.

Read the "Important Information About Your COBRA Continuation Coverage Rights" for more specific explanation regarding your COBRA rights and responsibilities.

SPECIAL NOTICE: If you were INVOLUNTARILY TERMINATED, you may be eligible for premium assistance. Please read the "Summary of the COBRA Premium Reduction Provisions under ARRA" at the end of this notice.

Important Information About Your COBRA Continuation Coverage Rights

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of coverage under the Plan required by Federal law. This law (known as COBRA) requires that most group health plans (including this Plan) give "Qualified Beneficiaries" the opportunity to continue their health care coverage when there is a "Qualifying Event" that would result in a loss of coverage under an employer's plan. Depending on the type of Qualifying Event, Qualified Beneficiaries can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee. (Certain newborn and newly-adopted children and alternate recipients under a Qualified Medical Child Support Order (QMCSO) may also be Qualified Beneficiaries.

What is the American Recovery and Reinvestment Act of 2009 (ARRA)?

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. If you experienced a loss of coverage on or after March 1, 2009 or prior to January 1, 2010 as a result of an involuntary termination of employment, you may be eligible for the temporary premium reduction for up to nine months. To help determine whether you can get the ARRA premium reduction, you should read the materials included in this packet carefully. In particular, reference the "Summary of the COBRA Premium Reduction Provisions under ARRA" with details regarding eligibility, restrictions, and obligations and the "Application for Treatment as an Assistance Eligible Individual." **If you believe you meet the criteria for the premium reduction, complete the "Application for Treatment as an Assistance Eligible Individual"**

How can you elect COBRA continuation coverage?

To elect COBRA continuation coverage, you must fully complete the COBRA Election Form according to the directions on the COBRA Election Form and mail, fax or hand-deliver it to the EUTF by the date specified on the COBRA Election Form. **If you fail to do so, you will lose your right to elect COBRA continuation coverage under the Plan.** Each Qualified Beneficiary has a separate right to elect COBRA continuation coverage. For example, the employee's spouse may elect COBRA even if the employee does not. A parent may elect COBRA on behalf of only one, several or all dependent children who are Qualified Beneficiaries. The employee or the employee's spouse can elect COBRA on behalf of all of the Qualified Beneficiaries in the family.

You may elect COBRA continuation coverage under any or all of the group health components of the Plan listed on Continuation Coverage (COBRA) Election Form, Part B, under which you were covered on the day before the Qualifying Event occurred.

Am I eligible for the premium reduction?

If you lost group health coverage through December 31, 2009 due to an involuntary termination of employment and are not eligible for Medicare or other group health plan coverage, you are entitled to receive the premium reduction. Information about the amount of the premium reduction and how it affects your premium payments can be found below under the question, "How much does COBRA continuation coverage cost?"

How long will COBRA continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee may last for up to 36 months after the date of Medicare entitlement; the employee's COBRA continuation coverage may last for up to 18 months after the Qualifying Event.

In the case of losses of coverage due to an employee's death, divorce or legal separation or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to a total of 36 months.

The maximum period of COBRA continuation coverage available to the listed Qualified Beneficiaries is shown on the cover letter of this Notice.

Continuation coverage will automatically terminate before the end of the maximum COBRA coverage period if:

1. any required premium is not paid in full on time;
2. a Qualified Beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan (but only after any preexisting condition exclusions for any preexisting conditions of the Qualified Beneficiary have been exhausted or satisfied);
3. a Qualified Beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA continuation coverage;
4. the employer ceases to provide any group health plan for its employees; or
5. during a disability extension period described below, the Social Security Administration determines that a disabled Qualified Beneficiary is no longer disabled.

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the EUTF of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

You must provide the EUTF with notice of the Social Security Administration's disabilitydetermination within 60 days after the latest of:

1. the date of the Social Security Administration's disability determination;
2. the date of the covered employee's termination of employment or reduction in hours of employment; or

3. the date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the covered employee's termination of employment or reduction in hours of employment.

In addition, in order to be entitled to the disability extension you must provide the EUTF with notice of the Social Security Administration's disability determination within 18 months after the covered employee's termination of employment or reduction in hours of employment. If you provide notice to the EUTF of the Social Security Administration's disability determination at a date more than 18 months after the covered employee's termination of employment or reduction in hours of employment, you will not be entitled to the disability extension, even if you provided the notice within 60 days after receiving the Social Security Administration's disability determination.

You must provide notice of the disability determination in writing by appropriately completing the attached "Notice of a COBRA-Related Event." You must follow the procedures specified below in the section entitled "Notice Procedures" and you must return the signed and dated form along with appropriate supporting documentation of the Social Security Administration's disability determination within the time period described above. The section entitled "Notice Procedures" also describes what the Plan will accept as appropriate supporting documentation of the initial Qualifying Event. Oral notice, including notice by telephone, is not acceptable, and electronic notice by e-mail is not acceptable. You may return the "Notice of a COBRA-Related Event" to the EUTF by mail, by fax or by hand-delivery according to the procedures specified below in the section entitled "Notice Procedures." If you do not follow these procedures or if you fail to provide written notice to the EUTF within the 60-day notice period described above, **THEN YOU AND ANY OTHER FAMILY MEMBERS WHO ARE QUALIFIED BENEFICIARIES WILL NOT BE ENTITLED TO THE THE DISABILITY EXTENSION OF YOUR COBRA CONTINUATION COVERAGE.**

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

For second Qualifying Events (death of the employee, divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must provide the EUTF with written notice of the second Qualifying Event within 60 days after the second Qualifying Event occurs.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the COBRA Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day

gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. If you do elect continuation coverage under this additional election period, the period from qualifying event to the date coverage begins under your election will not count as a break in coverage in determining whether you had a 63-day break in coverage.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

The American Recovery and Reinvestment Act of 2009 (ARRA) reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with December 31, 2009. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to nine months. If your COBRA continuation coverage lasts for more than nine months, you will have to pay the full amount to continue your COBRA continuation coverage. See the attached "Summary of the COBRA Premium Reduction Provisions under ARRA" for more details, restrictions, and obligations as well as the form necessary to establish eligibility.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the COBRA Election Form. The insurance carriers will provide you with a payment notice. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the appropriate insurance carrier to confirm the correct amount of your first payment.

First payment for COBRA continuation coverage

If you elect COBRA continuation coverage, DO NOT send any payment with the COBRA Election Form. You will be billed by the insurance carrier. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. This is the date the Election Notice is post-marked when you mail it back to us, the date embedded in the fax transmittal if you fax the Election Notice back to us, or the date stamped on the Election Notice if you hand-deliver the notice to us. **If you do not make your first payment for COBRA continuation coverage in full within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan.**

Your first payment must cover the cost of COBRA continuation coverage first day after your coverage under the Plan terminated up through the end of the month before the month in which you make your first premium payment. You are responsible for making sure that the amount of your first payment is correct. If you are not sure about the amount of your first COBRA premium payment, you may access the COBRA rates at the EUTF website. Otherwise, you can contact the COBRA Coordinator at the Hawaii Employer-Union Health Benefits Trust to confirm the correct amount of your first payment.

Grace periods for periodic payments

Although periodic payments are due on the first day of the coverage month, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan may be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first COBRA premium payment should be sent to the appropriate insurance company at the address shown in the attachment or as instructed by the insurance company.

For more information

This notice does not fully describe COBRA continuation coverage or other rights under the Plan. More information about COBRA continuation coverage and your rights under the Plan is available in the COBRA

General Notice Reference Guide and in the "COBRA Notice" both of which are available on-line at the EUTF's website at: www.eutf.hawaii.gov or from the EUTF.
If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of the appropriate Reference Guide, you should contact the EUTF at:

Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, HI 96805-2121
Telephone: (808) 586-7390
Toll Free: (800) 295-0089

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa. State and local government employees should contact HHS-CMS at www.cms.hhs.gov/COBRAContinuationofCov/ or NewCobraRights@cms.hhs.gov

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the EUTF informed of any changes in your your address and the addresses of family members. Submit any address changes using the attached Change of Address Form to the EUTF. You should also keep a copy, for your records, of any notices and forms you send to the EUTF.

Summary of the COBRA Premium Reduction Provisions under ARRA

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from February 17, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period. If you are currently enrolled in COBRA and you are determined to be eligible for premium reductions, your insurance carrier will either reimburse you for any over payment or credit your future payments. Please contact your insurance carriers for specific information. **NOTE: To be eligible for the premium subsidy, you must complete and submit the Request for Treatment as an Assistance Eligible Individual to the EUTF. You will be eligible for the premium subsidy only after your request is validated.**

♦ IMPORTANT ♦

◊ **If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.**

◊ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.

◊ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

Hawaii Employer-Union Health Benefits Trust Fund	**REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL**	P.O. Box 2121 Honolulu Hawaii 96805

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the next page)	Telephone Number E-mail address (optional)

TO QUALIFY, YOU MUST BE ABLE TO CHECK "YES" FOR ALL STATEMENTS.*

1. The loss of employment was involuntary	☐ Yes	☐ No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009.	☐ Yes	☐ No
3. I elected (or am electing) COBRA continuation coverage.*	☐ Yes	☐ No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium.)	☐ Yes	☐ No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium.)	☐ Yes	☐ No

***If you checked NO for Statement 3, you may still be eligible. See below for more information**

If your COBRA continuation coverage relates to an involuntary loss of employment prior to or on December 31, 2009, and you were eligible for, but waived COBRA coverage, you still have the right to to revoke your waiver and elect to enroll in COBRA. You must, however, revoke and submit your waiver in writing within the 60-day election period. In this scenario, your COBRA start date may begin on the date your waiver is revoked and therefore, your premium subsidy will not begin until that date. You can contact the EUTF at 586-7390 or toll free at 808-295-0089 or at 201 Merchant Street, Suite 1520, Honolulu Hawaii 96813 or go to our website at www.eutf.hawaii.gov for more information.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief, all of the answers I have provided on this form are true and correct.

Signature _____ Date_____

Type or print name:_____ Relationship to Employee:

FOR EMPLOYER VALIDATION

This application is: ☐ Approved ☐ Denied ☐ Approved for some/denied for others (explain in #4 below)

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary	☐
2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009.	☐
3. Individual was not enrolled in a health benefit plan when terminated.	☐

4. Other (please explain)

Signature of employer:

Signature _____ Date_____

Type or print name:_____	Position Title_____
Telephone Number:_____	E-mail address:_____

To apply for ARRA Premium Reduction, complete this form and return it to the EUTF along with you COBRA Election Form.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual to the EUTF at P.O. Box 2121, Honolulu HI 96805 or you can deliver it to our office at 201 Merchant Street, Suite 1520, Honolulu Hawaii 96813.

Be sure to read the important information about your rights and responsibilities included in the "Summary of the COBRA Premium Reduction Provisions under ARRA." For more detailed information, please access our website at www.eutf.hawaii.gov.

REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL (continued)

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name	Date of Birth	Relationship	SSN
a.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
b.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
c.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
d.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

Name	Date of Birth	Relationship	SSN
e.			

1. I elected (or am electing) COBRA continuation coverage.
2. I am NOT eligible for other group health plan coverage.
3. I am NOT eligible for Medicare.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name Relationship to employee

NOTE: If there are more dependents, please make a copy of this page and complete it for your additional dependents.

Selected FAQs For Employees About COBRA Premium Reduction Under ARRA
(Excerpts from the U.S. Department of Labor website edited for local use where necessary. You may the full FAQs at www.dol.gov/ebsa/cobra.html.

What plans does the premium reduction apply to?
The COBRA premium reduction provisions apply to all group health plans sponsored by State or local governments subject to the continuation provisions under the Public Health Service Act.

In order to be an Assistance Eligible Individual, must the individual actually have coverage under the group health plan at the time of the involuntary termination of employment?

In general, yes. The individual must have coverage at the time of the involuntary termination of employment. This qualifying event must occur at any time from September 1, 2008 through December 31, 2009 and the individual must be eligible for COBRA coverage at any time during that period.

How do I apply for the premium reduction?
If you were covered by an employment-based health plan on the last day of the employee's employment, you will receive a notice of your eligibility to elect COBRA and to receive the premium reduction. The notice should include any forms necessary for enrollment.

How does the 65% premium subsidy get paid to me?
You will not receive a payment. Assistance Eligible Individuals are responsible for paying only 35% of the COBRA premium for the period of coverage. The remaining 65% of the premium is reimbursed directly to the employer or insurance company through a payroll tax credit.

I was laid off from my job in December. Is that an involuntary termination of employment?
Being told not to come back to work until further notice is a termination of employment for purposes of COBRA and the ARRA premium reduction provisions. For more information on what is an involuntary termination of employment, see IRS guidance.

I am an assistance eligible individual who has been enrolled in COBRA coverage since December 2008. Will I receive a refund of 65% of all the premiums that I have already paid?
No. The premium reduction provisions apply only to premiums for coverage periods beginning on or after February 17, 2009.
Note: If you were eligible for the reduction but paid in full for periods of COBRA coverage beginning on or after February 17, 2009, you should contact applicable insurance carrier to determine if you will receive a credit against future payments or refund.

Only part of my family elected COBRA coverage but all of us were eligible. Can I enroll the others and take advantage of the premium reduction?
Each COBRA qualified beneficiary may independently elect COBRA coverage. Moreover, even if a family member did not elect COBRA coverage when first eligible, if the individual would be an Assistance Eligible Individual (except for his or her failure to elect COBRA coverage when first eligible or except because he or she discontinued COBRA coverage before February 17, 2009), that individual gets a second opportunity to enroll and qualify for the premium reduction.

What can I do if my former employer's group health plan denies my application for the premium reduction?

If the plan determines that you are not eligible for the premium reduction, you can request an expedited review of the denial. The Department of Labor will handle appeals related to private sector employer plans subject to ERISA's COBRA provisions. The Department of Health and Human Services will handle appeals for Federal, State, and local governmental employees, as well as appeals related to group health insurance coverage provided pursuant to state continuation coverage laws. The Departments are required to make a determination regarding your appeal within 15 business days after receiving your completed application for review.
Note: Appeals to the Department of Labor must be submitted on a U.S. Department of Labor application form. The form will soon be available at www.dol.gov/COBRA and can be completed online or mailed or faxed as indicated in the instructions. If you believe you have been inappropriately denied eligibility for the premium reduction, you may wish to speak with an Employee Benefits Security Administration Benefits Advisor at 1.866.444.3272 before filing this form.

How can I get more information on my eligibility for COBRA or the premium reduction?

Guidance and other information is available on the Department of Labor web site at www.dol.gov/COBRA. You can also call 1.866.444.3272 to speak to an Employee Benefits Security Administration Benefits Advisor. Information about the premium reduction provisions is also available from the IRS (http://www.irs.gov/newsroom/article/0,,id=204505,00.html) and Department of Health and Human Services (http://www.cms.hhs.gov/cobracontinuationofcov/), which, along with the Department of Labor, share responsibility for COBRA and the new requirements added by ARRA.

For general information regarding your plan's COBRA coverage or the administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, you can contact the EUTF Plan Administrator at 808-586-7390, toll free 800-295-0089 or via email at eutf@hawaii.gov. The mailing address is P.O. Box 2121, Honolulu HI 96805.

My family is currently enrolled in COBRA and receiving the 65% premium subsidy. I was recently hired and my new company is offering health benefits but I must pay 100% of the premiums for my family. It is much cheaper to remain on COBRA and therefore, I want to continue the plan with the subsidy. Can I continue under the subsidy program until the nine months have passed?

No, you and your family become ineligible for the subsidy once you are offered an opportunity to enroll in health benefits by your new employer. It is not based on your enrollment, just that you are eligible. You need to report your ineligibility to the EUTF. Please use the form below.

Hawaii Employer-Union Health Benefits Trust Fund	**NOTIFICATION OF INELIGIBILITY FOR COBRA PREMIUM ASSISTANCE**	P.O. Box 2121 Honolulu Hawaii 96805

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the next page)	Telephone Number E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION - Check one

I am eligible for coverage under another group health plan. If any dependents are also eligible, include their names below.	Enter the date you became eligible:

Enter the group health plan name: _____

If you are eligible for coverage under another group health plan and that plan covers dependents, you must also list their names here.

	_____ _____ _____ _____		_____ _____ _____ _____	

I am eligible for Medicare.	Enter the date you became eligible:

IMPORTANT

The American Recovery and Reinvestment Act of 2009 limits the period of premium assistance available to involuntarily terminated employees.

1 Up to nine months maximum

2 When you become eligible to enroll in another group heal plan

3 When you become eligible for Medicare benefits

4 For high income individuals, premium assistance is not available

If you have a modified adjusted income exceeding $125,000

If you file a joint return, a modified adjusted income exceeding $250,000

Failure to report your ineligibility timely may result in excess reimbursements. Any ineligible payments can be treated as an underpayment of your payroll taxes and may be assessed and collected in the same manner as payroll taxes in accordance with Subchapter B of Chapter 65 of the Internal Revenue Code of 1986, SEC. 6432. COBRA PREMIUM ASSISTANCE.

If you fail to notify the EUTF when you become eligible forother group health plan coverage or Medicare AND continue to pay reduced COBRA premiums, you could be subject to a fine of 110% of the amount of the premium reduction (Subchapter B of Chapter 65 of the Internal Revenue Code of 1986, SEC. 6720C.)

To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature:_____ Date:_____

Type or print your name:_____

NOTICE OF A COBRA-RELATED EVENT

Attn: Plan Administrator
Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, HI 96805-2121

The undersigned is hereby providing notice to the Plan Administrator of the Hawaii Employer-Union Health Benefits Trust Fund's (EUTF) group health plan(s) of the occurrence of a qualifying event or other COBRA-related event. Notice is being provided in order to preserve the COBRA continuation coverage rights of the undersigned and all related qualified beneficiaries/covered dependents who are or were covered under the EUTF's group health plan(s).

The following COBRA-related event occurred on _____ :
[enter date in mm/dd/yyyy format]

☐ divorce of the covered employee and covered spouse

☐ legal separation of the covered employee and covered spouse

☐ a covered dependent child ceased to be a dependent under the terms of the EUTF's plan(s)

☐ a 2nd qualifying event occurred after a qualified beneficiary has become entitled to COBRA with a maximum coverage period of 18 or 29 months; the 2nd qualifying event was: _____
_____

☐ after electing COBRA, a qualified beneficiary became covered under another group health plan

☐ after electing COBRA, a qualified beneficiary became entitled to coverage under Medicare (Part A, Part B, or both)

☐ the Social Security Administration determined that a qualified beneficiary with a maximum COBRA coverage period of 18 months was totally disabled at any time during the first 60 days of COBRA coverage

☐ the Social Security Administration determined that a qualified beneficiary previously determined to be disabled is no longer disabled

The following individuals/qualified beneficiaries covered under the EUTF's plan(s) are affected by this event:

_____
_____
_____
_____

Documentation of the event including the date of its occurrence is attached. Please take the appropriate steps to enable the qualified beneficiaries affected by this event to exercise their COBRA continuation coverage rights.

_____ _____
Signature Date

_____ _____
Name of Covered Employee Telephone Number

_____ _____
Mailing Address City, State, Zip Code

Keep a copy of the completed form for your records.

Instructions for Completing the"Notice of a COBRA-Related Event"

The person completing this form should do the following:

1. Complete the form using blue or black ink. Do not use pencil. Write or print legibly.

2. Fill in the date that the event you are reporting occurred. Either show the date in full, for example, April 5, 2005 or use a month/day/year format, for example, 4/5/2005.

3. Check the box corresponding to the qualifying event or other COBRA-related event you are reporting. If none of the boxes apply, call the Plan Administrator at (808) 586-7390 for assistance.

4. List the names of all family members who (1) are or were covered under the Plan and (2) whose coverage under the Plan may be affected by the event you are reporting. Be sure to include your own name if it is appropriate.

5. Be sure to sign and date the form. Make a copy of the completed form and keep it in a safe place.

6. Indicate the name of the employee covered under the Plan. Show the employee's first name, middle initial and last name. Be sure to write or print legibly.

7. Indicate a current telephone number where the Plan Administrator may call you if there are any questions regarding your Notice.

8. Indicate the current mailing address where the Plan Administrator should send the COBRA Election Form or other correspondence. If you are reporting an event that affects the coverage of any family member who does not reside with you (for example, a child away at school), please note their current mailing address on the back of the form.

9. **Attach appropriate documentation to verify the date of the event you are reporting.** The "COBRA Notice" on the Plan's website provides examples of appropriate documentation for the different events. Call the Plan Administrator at (808) 586-7390 if you have any questions regarding the documentation you should provide.

10. Review the form to make sure it is complete. If you have any questions about completing the form, call the Plan Administrator at (808) 586-7390.

11. Return the completed form to the Plan Administrator at the address shown on the top of the Notice. You may return the Notice by mail, by fax, or you may deliver it by hand. You may fax the Notice to the Plan Administrator at (808) 586-2161. You may hand-deliver the Notice to the Plan Administrator at 201 Merchant Street, Suite 1520, Honolulu, HI.

12. If you mail the Notice, be sure to affix sufficient postage to the envelope. If the Postal Service returns your Notice because of insufficient postage, you may not be able to re-mail the notice in a timely manner. If your Notice is late, you will forfeit your rights under COBRA and you will not be entitled to elect or extend COBRA continuation coverage.

13. If you fax the Notice, be sure to keep a copy of the fax transmittal report showing the date and time the Notice was transmitted, the fax number that received the Notice and the status of the fax transmission.

CHANGE OF ADDRESS FORM

Attn: COBRA Coordinator
Hawaii Employer-Union Health Benefits Trust Fund
P.O. Box 2121
Honolulu, HI 96805-2121

The undersigned is hereby providing notice to the COBRA Coordinator of the EUTF's group health plan(s) of a change in the mailing address of an employee, Qualified Beneficiary or other Plan Participant. The individuals identified below reside at the addresses shown below as of the date of this Form.

_____	_____
Name	*Name*
_____	_____
Mailing address	*Mailing address*
_____	_____
City, State, Zip code	*City, State, Zip code*
_____	_____
Relationship to Employee	*Relationship to Employee*
_____	_____
Name	*Name*
_____	_____
Mailing address	*Mailing address*
_____	_____
City, State, Zip code	*City, State, Zip code*
_____	_____
Relationship to Employee	*Relationship to Employee*
_____	_____
Signature of Employee	Date
_____	_____
Name of Employee	Social Security Number of Employee

WHAT IS CONSIDERED TO BE INVOLUNTARY TERMINATION? (excerpt from IRS Notice 2009-27 and edited for EUTF applicability)

The following extract is provided to assist you in determining whether or not an employee is eligible to be considered "involuntarily terminated" from his/her job. Only the employer can make this determination. The EUTF will process a termination based upon the input from the employer and will not make any determination nor interpretation whether a voluntary or involuntary termination is involved.

The Q&A's apply solely for purposes of determining whether there is an involuntary termination under section 3001 of ARRA (including new Code sections added by section 3001 of ARRA), but not for any other purposes under the Code or any other law.

Question. What circumstances constitute an involuntary termination for purposes of the definition of an assistance eligible individual?

Answer. An involuntary termination means a severance from employment due to the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services. An involuntary termination may include the employer's failure to renew a contract at the time the contract expires, if the employee was willing and able to execute a new contract providing terms and conditions similar to those in the expiring contract and to continue providing the services. In addition, an employee-initiated termination from employment constitutes an involuntary termination from employment for purposes of the premium reduction if the termination from employment constitutes a termination for good reason due to employer action that causes a material negative change in the employment relationship for the employee.

Involuntary termination is the involuntary termination of employment, not the involuntary termination of health coverage. Thus, qualifying events other than an involuntary termination, such as divorce or a dependent child ceasing to be a dependent child under the generally applicable requirements of the plan (such as loss of dependent status due to aging out of eligibility), are not involuntary terminations qualifying an individual for the premium reduction.

In addition, involuntary termination does not include the death of an employee or absence from work due to illness or disability. The determination of whether a termination is involuntary is based on all the facts and circumstances. For example, if a termination is designated as voluntary or as a resignation, but the facts and circumstances indicate that, absent such voluntary termination, the employer would have terminated the employee's services, and that the employee had knowledge that the employee would be terminated, the termination is involuntary.

Question. Does an involuntary termination include a lay-off period with a right of recall or a temporary furlough period?

Answer. Yes. An involuntary reduction to zero hours, such as a lay-off, furlough, or other suspension of employment, resulting in a loss of health coverage is an involuntary termination for purposes of the premium reduction.

Question. Does an involuntary termination include a reduction in hours?

Answer. Generally no. If the reduction in hours is not a reduction to zero, the mere reduction in hours is not an involuntary termination. However, an employee's voluntary termination in response to an employer-imposed reduction in hours may be an involuntary termination if the reduction in hours is a material negative change in the employment relationship for the employee.

Question. Does involuntary termination include an employer's action to end an individual's employment while the individual is absent from work due to illness or disability?

Answer. Yes. Involuntary termination occurs when the employer takes action to end the individual's employment status (but mere absence from work due to illness or disability before the employer has taken action to end the individual's employment status is not an involuntary termination).

Question. Does an involuntary termination include retirement?

Answer. If the facts and circumstances indicate that, absent retirement, the employer would have terminated the employee's services, and the employee had knowledge that the employee would be terminated; the retirement is an involuntary termination.

Question. Does involuntary termination include involuntary termination for cause?

Answer. Yes. However, for purposes of COBRA, if the termination of employment is due to gross misconduct of the employee, the termination is not a qualifying event and the employee and other family members losing health coverage by reason of the employee's termination of employment are not eligible for COBRA continuation coverage.

Question. Does an involuntary termination include a resignation as the result of a material change in the geographic location of employment for the employee?

Answer. Yes.

Question. Does an involuntary termination include a work stoppage as the result of a strike initiated by employees or their representatives?

Answer. No. However, a lockout initiated by the employer is an involuntary termination.

Question. Does an involuntary termination include a termination elected by the employee in return for a severance package (a "buy-out") where the employer indicates that after the offer period for the severance package, a certain number of remaining employees in the employee's group will be terminated?

Answer. Yes.